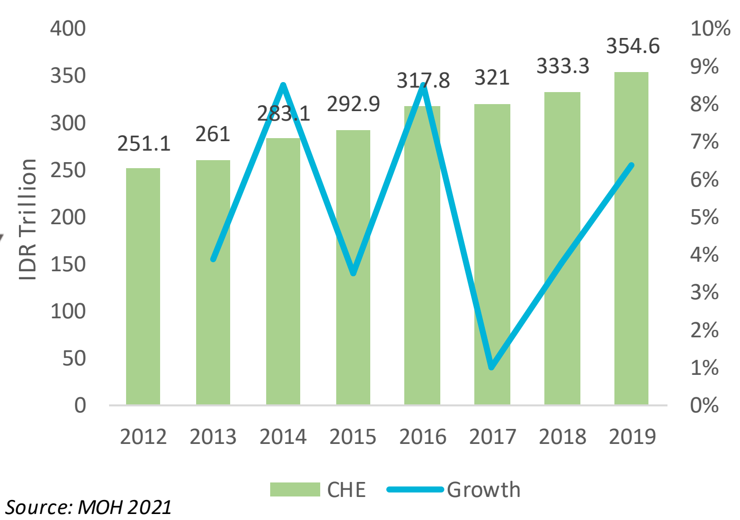
SP4PHC
Strategic Purchasing for Primary Health Care

Indonesia Health Purchasing Profile

September 2022

Indonesia is the largest archipelagic nation in the world and the fourth most populous country. The country's health system is facing the double-burden of communicable and noncommunicable diseases, that is also straining its young national health insurance scheme, JKN, which started in 2014. SP4PHC works with the Ministry of Health (MOH) to support reforms that strengthen strategic purchasing, with a focus on family planning (FP) and maternal and child health (MCH). Below are general health financing statistics to better understand current health expenditure (CHE), sources of revenue, and out-of-pocket (OOP) expenditure.

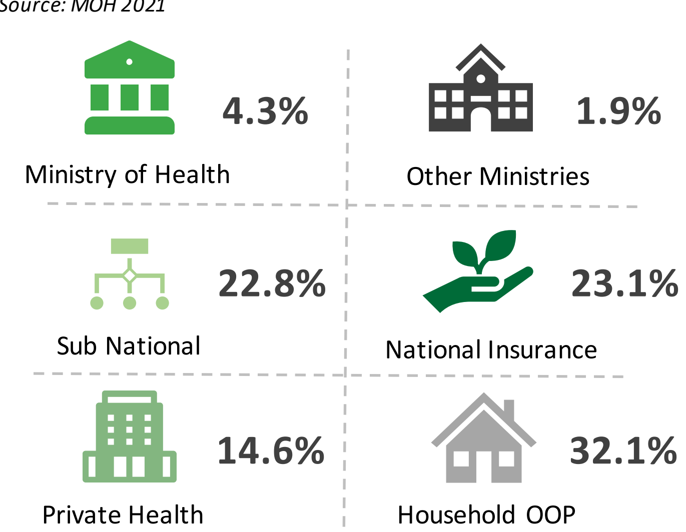
Indonesia's Current Health Expenditure (2012-2019)



Source: MOH 2021

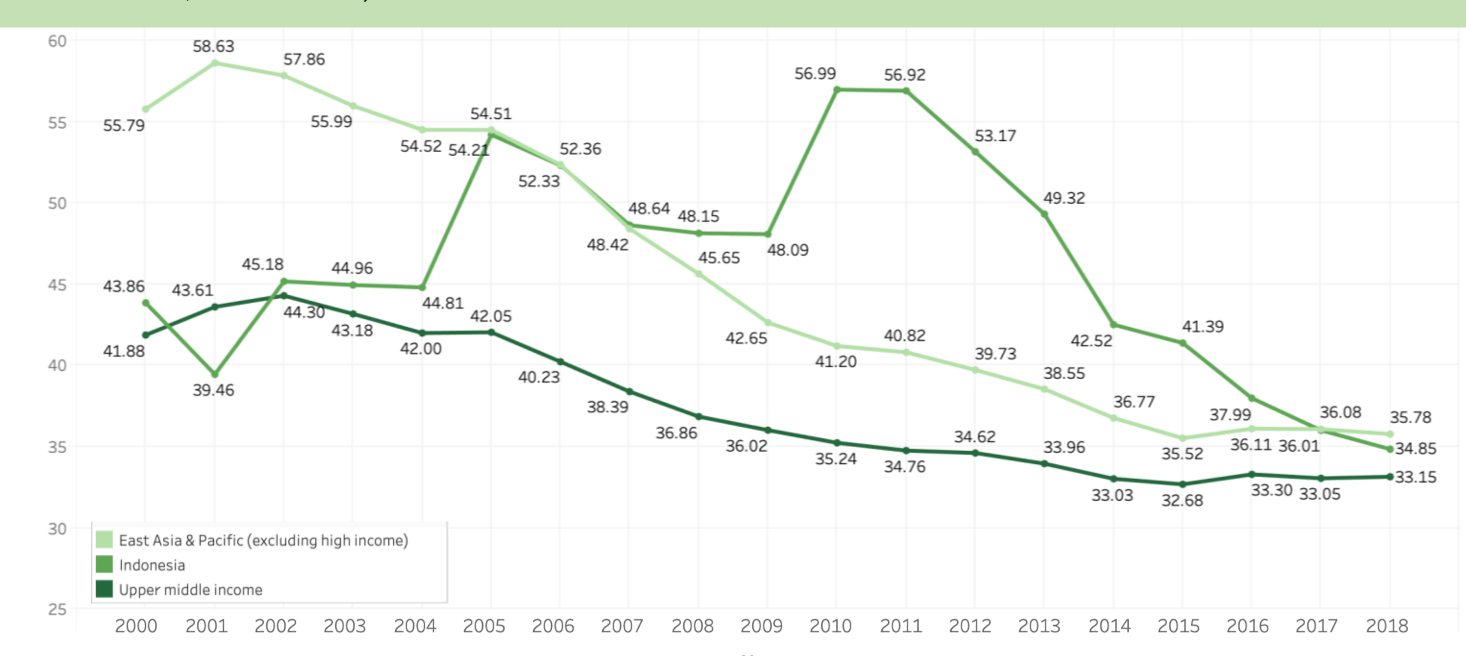
Indonesia's Health Expenditure by Purchaser (2019)

Source: MOH 2021



Trends in OOP expenditure as a percentage of CHE in Indonesia

Source: World Bank, accessed 28 January 2021



OOP health expenditure in Indonesia has followed regional trends, as it has greatly decreased in the last 20 years. However, over 34% of CHE is still comprised of OOP payments even though over 84% of Indonesians are covered by JKN.

Strategic Purchasing for Primary Health Care (SP4PHC) is a project that ThinkWell is implementing in partnership with government agencies and local research institutions in five countries (Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda), with support from the Bill & Melinda Gates Foundation.

Purchasing vs. Strategic Purchasing

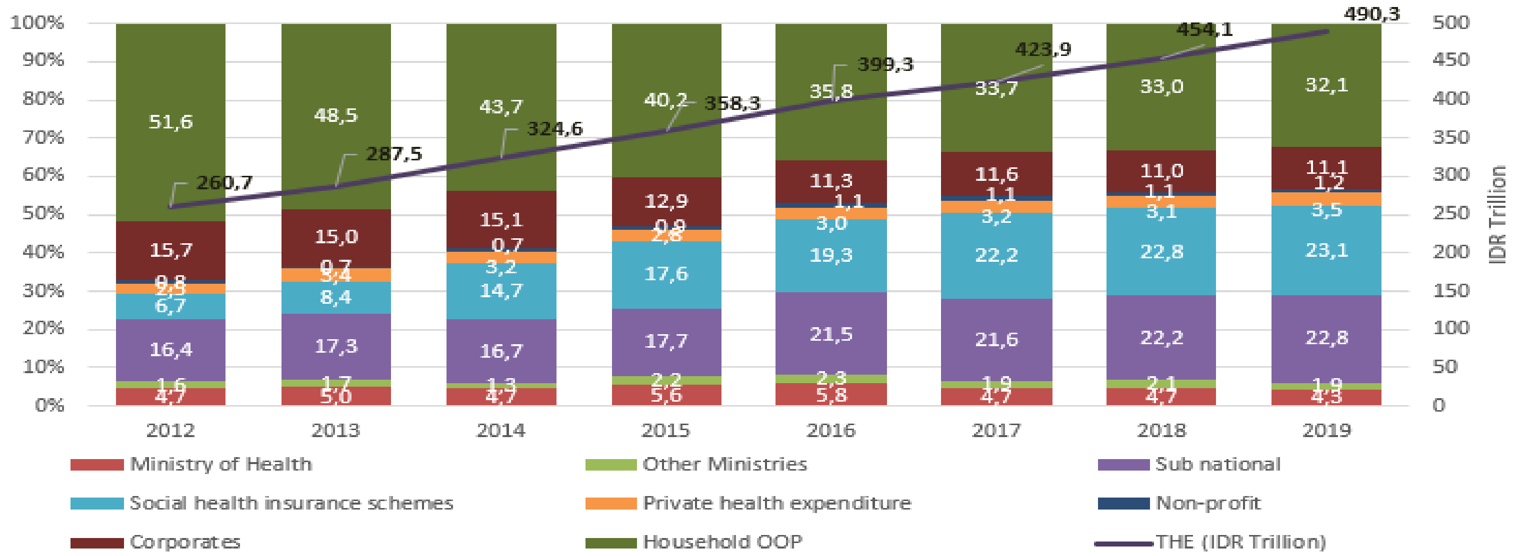
Source: [1] World Health Report 2000 [2] World Health Report 2010

As countries such as Indonesia implement strategies to achieve universal health coverage (UHC), they are undertaking reforms to mobilize more financing for health and ensure that available funds are used optimally and equitably. Strategic purchasing is linked to the second objective. Making purchasing strategic means basing purchasing decisions on information about provider behavior and population health needs. However, most countries have multiple purchasers and purchasing schemes and these reforms are often added to existing systems without addressing the fragmentation.

Under SP4PHC, ThinkWell is working with individual purchasers critical for the delivery of PHC, especially family planning (FP) and maternal, newborn, and child health (MNCH) services, and assisting governments to improve coherence between purchasing arrangements at the system-level. The figure below shows the fragmentation in Indonesian health spending, with OOPs remaining stubbornly high even as social health insurance (JKN) spending grows.

Trends in Indonesia Health Expenditure 2012-2019

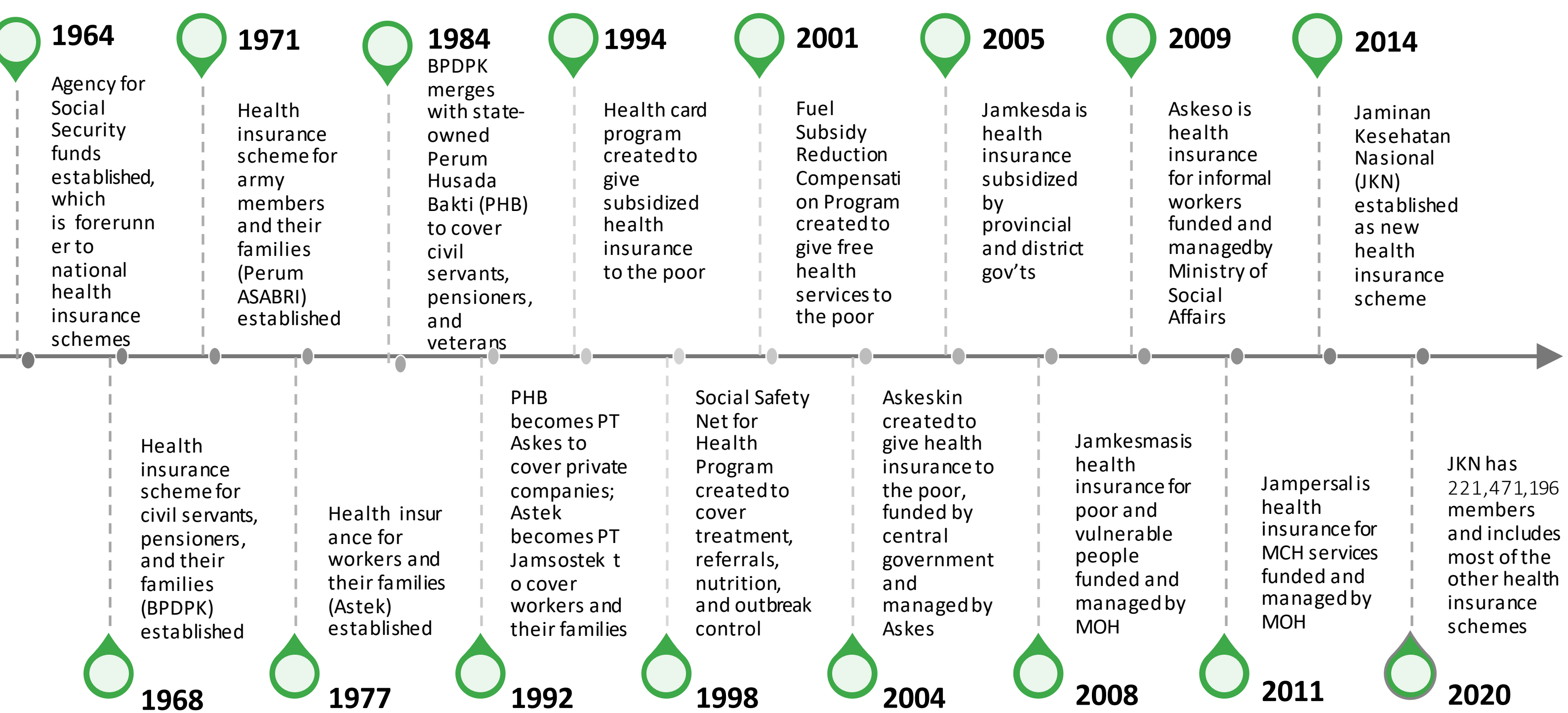
Source: National Health Account Indonesia, 2021



Health Financing Timeline

Source: BPJS-Ketenagakerjaan 2017; ASABRI 2017; BPJS-Kesehatan 2020; Jurnal Kesehatan Masyarakat Nasional 2008; BAPPENAS 2008; Universitas Indonesia 2008; Widayanti n.d.

Since gaining independence in 1945, Indonesia has experienced significant changes in government, population, and population health, resulting in ambitious health financing initiatives aimed at addressing these evolving needs.



Fund Flow for Health Services

Funding for the health sector in Indonesia is fragmented. Law No.22/1999 gave subnational governments (especially at the district level) greater autonomy in raising and allocating budgets. As such, funds from the national government mostly go to BPJS-K (the implementing agency for JKN), but there are also allocations for MOH-managed hospitals, subnational government transfers, and priority health programs. Subnational governments must allocate at least 10% of their annual budgets to pay for health, which can include service delivery for key priority programs, certain public facilities, and subsidies for the poor to access JKN. The funds that go into BPJS-K are then spent through a variety of provider payment mechanisms, including case-based group, monthly capitation, and fee-for-service payments to public and private providers. Notably, PHC facilities are supposed to serve as gatekeepers to more expensive levels of care.

DAU transfer & cigarette tax

Sources of revenue

Central Government

Gov't allocation

Ministry of Health

DAK transfer

Local Government

National Social Security Council (DJSN) - Oversees BPJS-K

Subsidy for PBI (national)

Subsidy for PBI (local)

Budget item

Main Purchaser

JKN/BPJS-K – implements NHI scheme

Capitation + FFS

DJSN Oversees JKN

Capitation + FFS

CBG

CBG

Budget item

FFS

Healthcare Providers

Private PHC Facility

Public Referral Hospital

Private Referral Hospital

Public PHC Facility

Public & Private Midwives

FFS

Public health programs

3 flat rate options

JKN Members/ Indonesian Population

Informal Workers

Formal Workers

Poor (PBI)

5% wages, IDR 12 million max

Payments or claims

Contributions

Tax or budget allocation

Health Services

Note: BPJS-K = Badan Penyelenggara Jaminan Sosial – Kesehatan (Social Insurance Administering Body for Health). BPJS-K manages JKN.

PBI = Members who are listed as poor and vulnerable and their coverage is subsidized by the government
CBG = Case-based groups are set reimbursement rates for health services
DAU = General funds that are allocated by the national government to subnational governments
DAK = Earmarked funds allocated by the national government to subnational governments specifically to support disadvantaged district provide public program, with priority given to national health programs

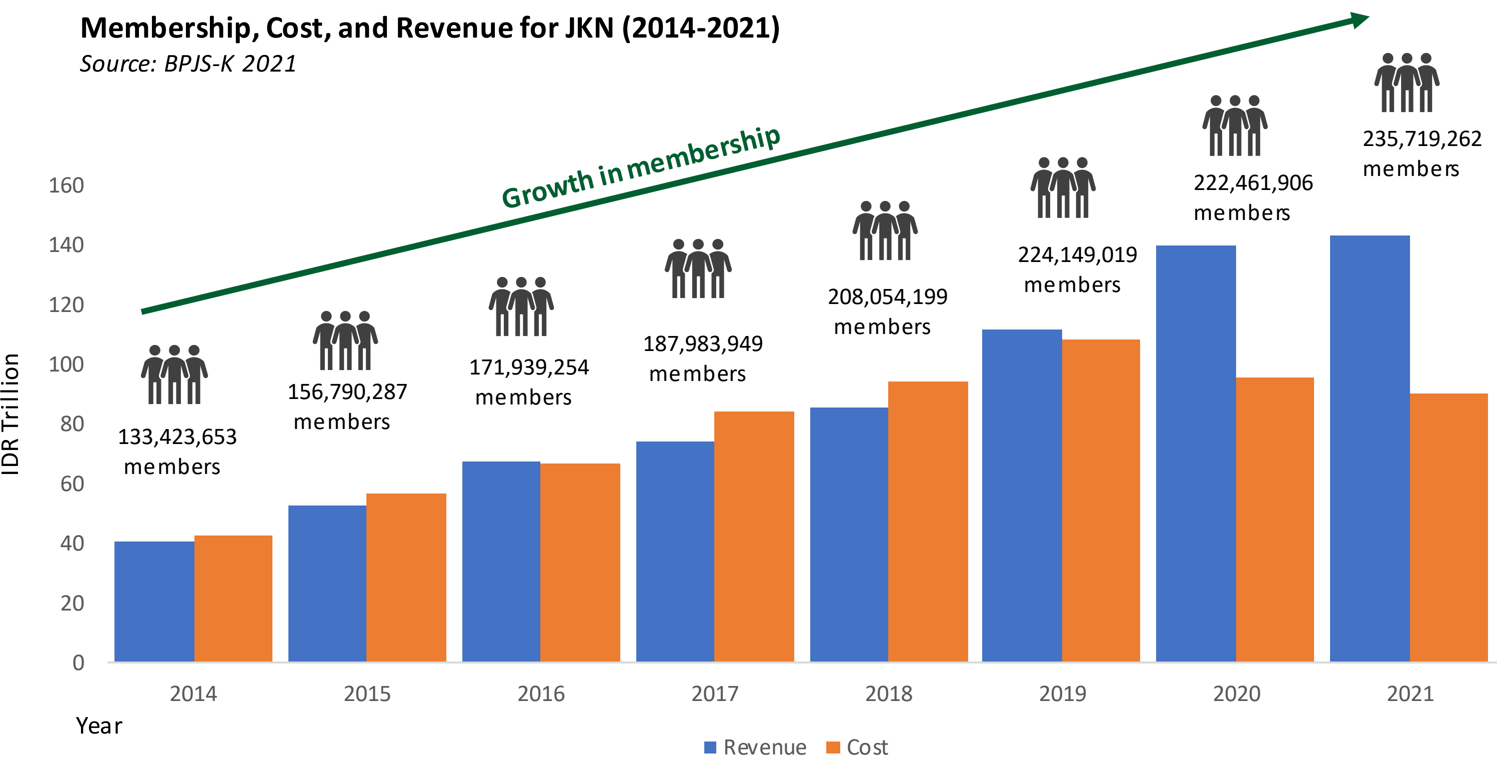
PHC facilities are gatekeepers. In other words, in order to access secondary or tertiary care, you generally need to be referred to by a PHC provider first.

Figure adapted from Agustina et al. 2019

There are several different purchasers in Indonesia, with a range of attributes. Historically, these purchasers have not aligned well with one another, leading to fragmentation and inefficiencies in the health financing landscape. National level programming and sub-national financing of health care still play a substantial role in purchasing in Indonesia, even with the introduction of JKN, which covers over 80% of the population. Still, the JKN scheme allows the most flexibility and opportunity (with its purchaser-provider split) to institute strategic purchasing mechanisms that can effectively respond to the diverse health needs and challenges the archipelago presents.

Purchaser attributes	National Government	Sub-national Government	National Health Insurance (JKN)
Sources of revenue (e.g., taxes, premiums)	National taxes, loans, and grants	Provincial- and district-level governments can collect separate taxes (e.g., cigarettes) and fees (e.g., business licenses) They each can also receive from the national government budget transfers (e.g., health program allocations), grants	Tax subsidy for targeted populations and general taxes Monthly contributions for waged workers at 5% of wages, split between employer and employee Monthly contributions for non-waged/informal workers a flat rate ranging from IDR 42,000 – 150,000
Population covered (e.g., poor, formal sector)	General public	General public in sub-national areas	Formal and informal sector covered after contributions; poor are automatically covered without contribution
Benefits/services covered (e.g., PHC, hospitalization, inpatient, outpatient, etc.)	Promotive and preventive programs, TB, Malaria, and HIV; operational fund for primary health care (PHC) and hospital; special fund allocation for facility infrastructure at subnational level	Services offered depend on variable sub-national fiscal capacity and commitment; promotive and preventive program, etc.; operational funds for public PHC facilities and hospitals	FP services (counseling & methods), ANC, deliveries, c-sections, postnatal care
Types of facilities included (e.g., referral hospitals, health centers, health posts, etc.)	Only public PHC facilities and public referral hospitals; automatic contracting	Mostly public PHC facilities and public referral hospitals; sub-national governments can contract with private providers	PHC facilities and referral hospitals (public and private); nearly 60% contracted are private providers, via selective contracting
Payment methods (with FP and MCH specifics)	Line-item budget; National Population and Family Planning Board buys the FP commodities and distributes subnational to public healthcare facilities	Line-item budget; Sub-national authority buys additional FP commodities, distributes to public facilities	Capitation to PHC facilities; non-capitation rates (quasi-fee-for-service) to PHC facilities for FP and MNH services; case-based groups for referral hospitals

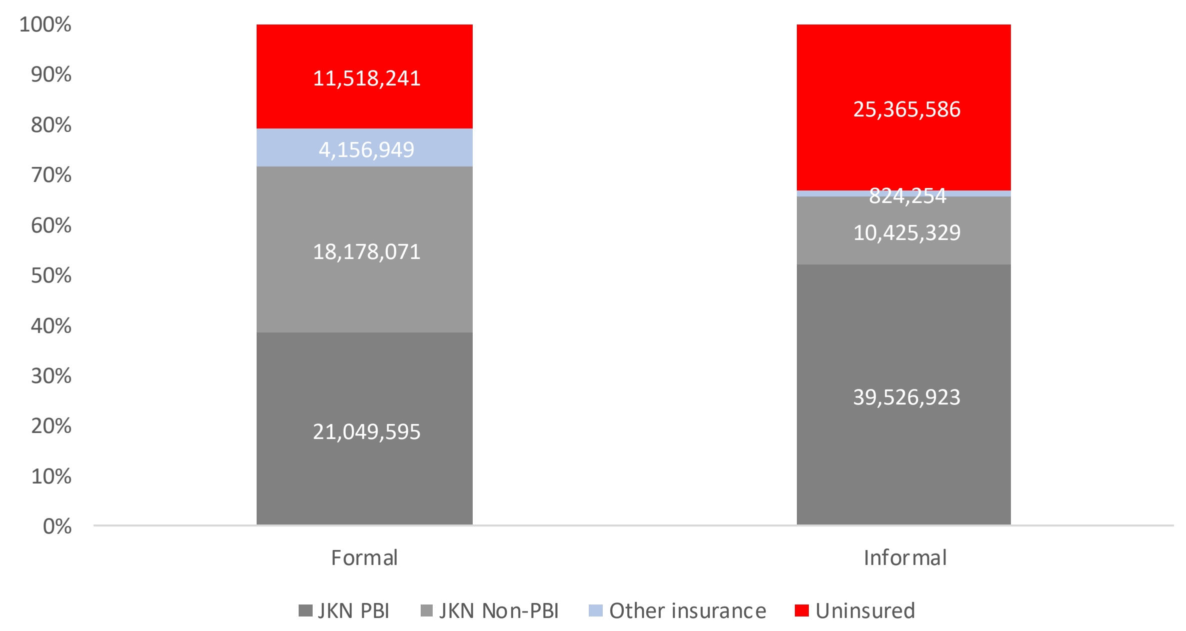
While JKN coverage is rapidly growing, there is growing concern about the financing sustainability of the scheme with consistently rising costs. Since 2016, JKN has been running a deficit which has caused the Government of Indonesia to consider health financing reforms to ensure continuing coverage without sacrificing the UHC goals of financial protection and equitable access to quality health services.



While JKN coverage is rising, the scheme still struggles to fully include the large informal sector in Indonesia. Those of the informal sector that are covered by JKN, are much likelier to be poor and part of the subsidized JKN PBI membership group.

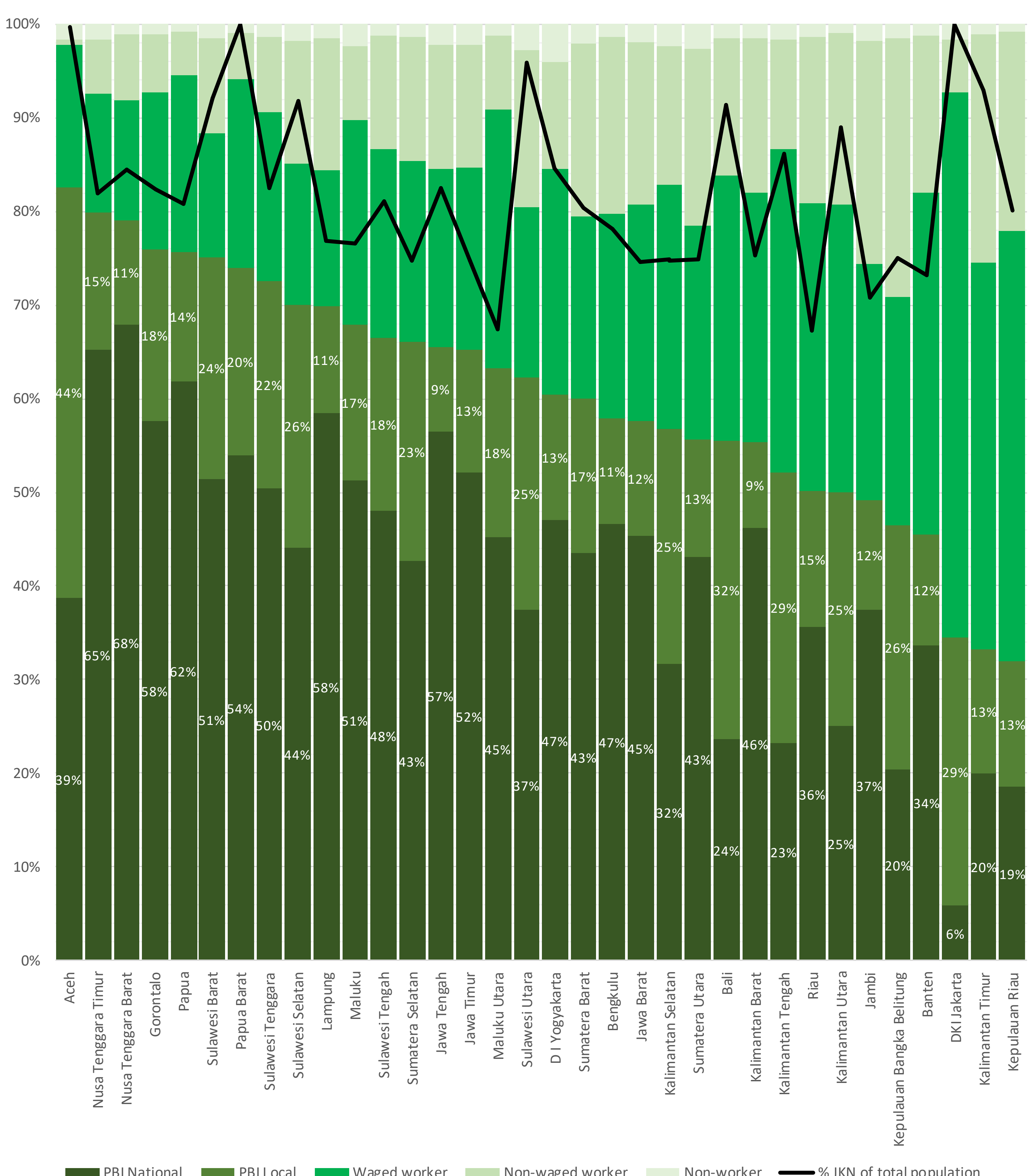
Percentage coverage of formal and informal workers, by insurance type

Source: Susenas (Indonesia National Socioeconomic Survey) 2021



JKN membership breakdown by province. *Source: Indonesia Health Profile, 2020*

The figure below shows JKN coverage at the district level, broken down by membership type. It is sorted by the proportion of covered members that are poor – from left to right, districts with more covered poor to districts with less. PBI generally constitutes a majority of JKN members, especially in the less developed provinces towards the East of the country. The rise in coverage, especially for subsidized vulnerable populations, contributes to the rise in costs to the government. This has implications for the sustainability of JKN.

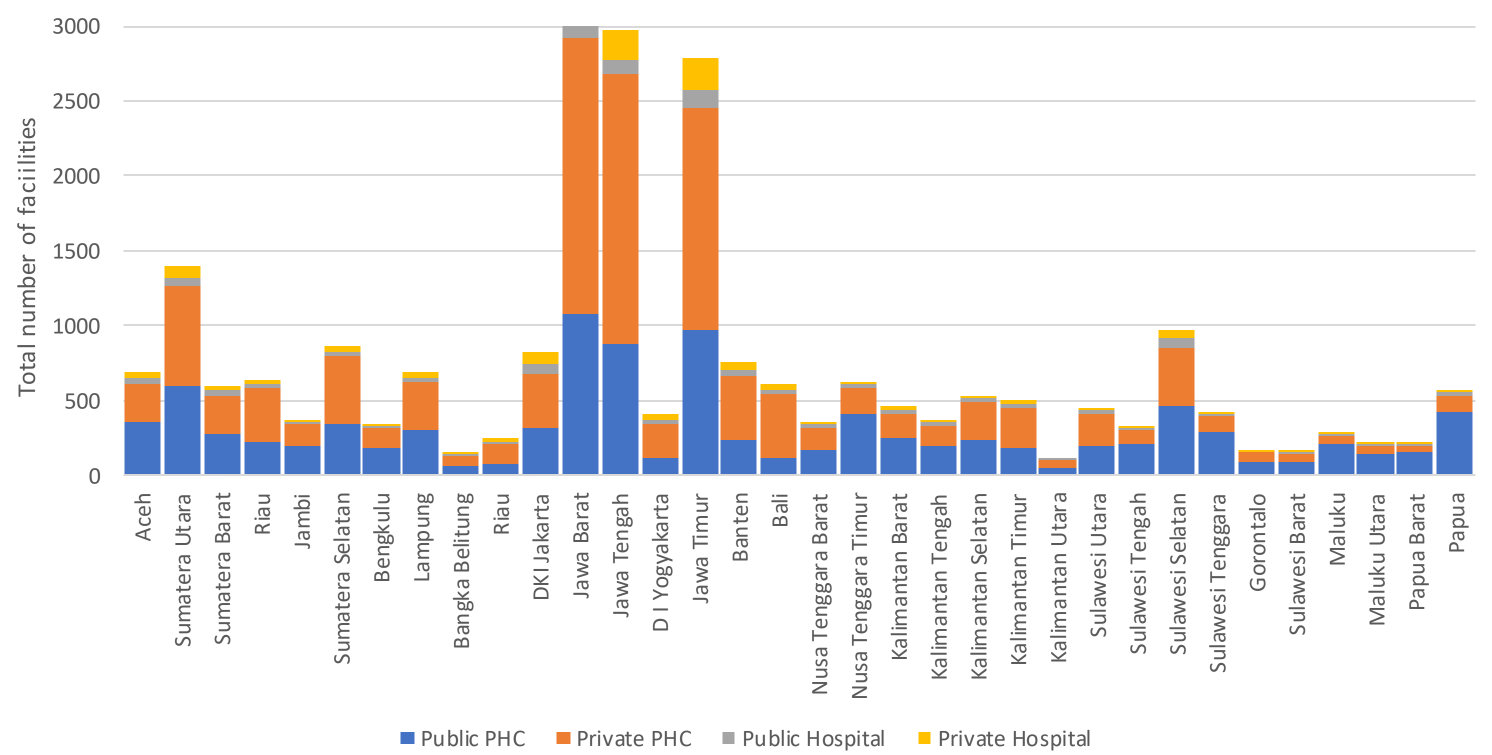


Supply-side readiness (SSR), both physical (i.e: the number of public and private facilities) and nonphysical (i.e: human resource and the use of information technology), is still sub-optimal across the country. Western provinces show a slightly higher SSR index (lighter yellow and orange colors) compared to eastern ones (with more red). Higher SSR index appears to occur in more developed provinces such as Jakarta, Bali, and Jawa Timur. Meanwhile, the index is lower (more red) among provinces without these urban centers.

Source: Maulana, Nirwan, et al. 2021. Expanding Coverage and Readiness in Indonesia: How JKN Coverage and Supply-Side Readiness Influence Out-of-Pocket Payments across the Archipelago. Indonesia Brief 3. Jakarta, Indonesia: ThinkWell.

Facilities contracting with JKN, broken down by province. *Source: Indonesia Health Profile, 2020*

Western, more urban provinces have more providers, driven by the higher availability of private sector. Eastern provinces have far less health facilities and are largely made of public PHC facilities and have very few private providers.



The interaction between JKN coverage, supply-side readiness, and OOP payments

There is a joint influence of JKN coverage and SSR on out-of-pocket (OOP) health expenditure. Changes in average share of household OOP to total nonfood expenditure between 2018 and 2019 for each province in Indonesia are captured in the parentheses next to each province name. Typically, provinces with reduced OOP health spending above the national average (-10.8%) have high JKN coverage or a high SSR index (which was calculated by the team in this brief). In contrast, provinces with low JKN coverage or a low SSR index have lower OOP reduction, below the median level, and even OOP in some provinces are increasing. This analysis shows the importance of not only just the spread of JKN coverage, but of supply-side readiness to improve the affordable access to PHC services across the different provinces of Indonesia.

*(OOP Changes in 2018-2019)

Supply-Side Readiness Index (I)

JKN Coverage at HH level (JKN)

100%
60%
20%
-20%
-60%
-100%

-70% -50% -30% -10% 10% 30% 50% 70%

Quadrant A:
JKN(province) > JKN(median)
I(province) < I(median)

Quadrant B:
JKN(province) > JKN(median)
I(province) > I(median)

Quadrant C:
JKN(province) < JKN(median)
I(province) > I(median)

Quadrant D:
JKN(province) < JKN(median)
I(province) < I(median)

Sulawesi Barat (20%)
Papua (-18%)
Sulawesi Utara (-28%)
Gorontalo (-23%)
Sulawesi Selatan (-21%)
Maluku Utara (-16%)
Papua Barat (-18%)
Aceh (-14%)
Kalimantan Utara (-11%)
DKI Jakarta (-24%)
DI Yogyakarta (4%)
Kalimantan Selatan (-7%)
Bali (-3%)
Kalimantan Timur (-17%)
Bangka Belitung (-5%)
Sumatera Barat (-17%)
Jawa Tengah (-13%)
Kalimantan Barat (-8%)
Maluku (-3%)
Sulawesi Tengah (-10%)
Sumatera Utara (-11%)
Lampung (-10%)
Nusa Tenggara Timur (-24%)
Banten (-17%)
Sumatera Selatan (1%)
Kepulauan Riau (2%)
Sulawesi Tenggara (-5%)
Nusa Tenggara Barat (-4%)
Jambi (-19%)
Riau (-20%)
Jawa Barat (-4%)
Jawa Timur (-12%)
Kalimantan Tengah (-5%)
Bengkulu (-27%)

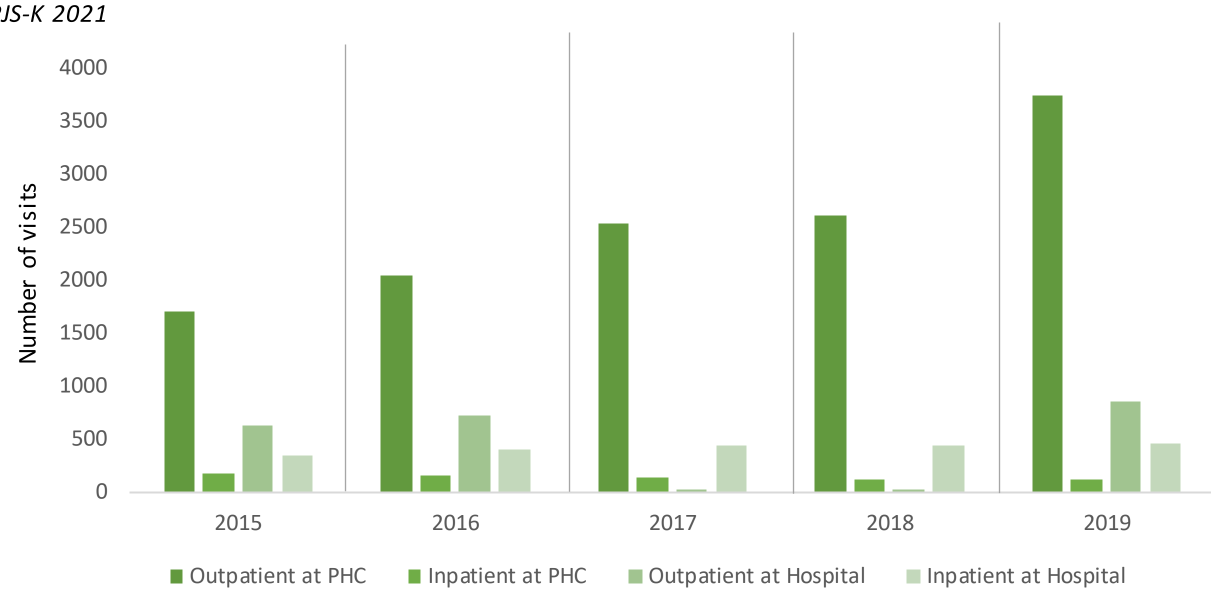
Source: Maulana, Nirwan, et al. 2021. Expanding Coverage and Readiness in Indonesia: How JKN Coverage and Supply-Side Readiness Influence Out-of-Pocket Payments across the Archipelago. Indonesia Brief 3. Jakarta, Indonesia: ThinkWell.

JKN effect on utilization and costs

Utilization of JKN has steadily increased from the introduction of JKN, with outpatient visits increasing the most. Even with this increased utilization, OOP payments (while slowly reducing) still make a significant proportion of health spending in the country. Much of this OOP spending is for drugs and curative care at private facilities. The team explored the effect of JKN on OOP spending more in this recently published journal article.

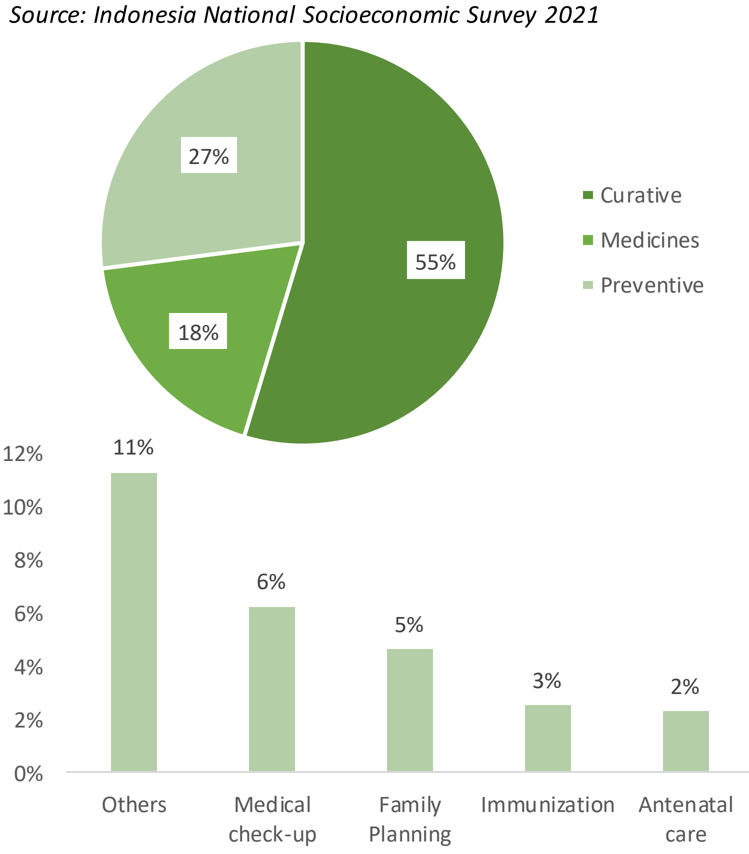
Utilization of Health Services per 100,000 members (2015-2019)

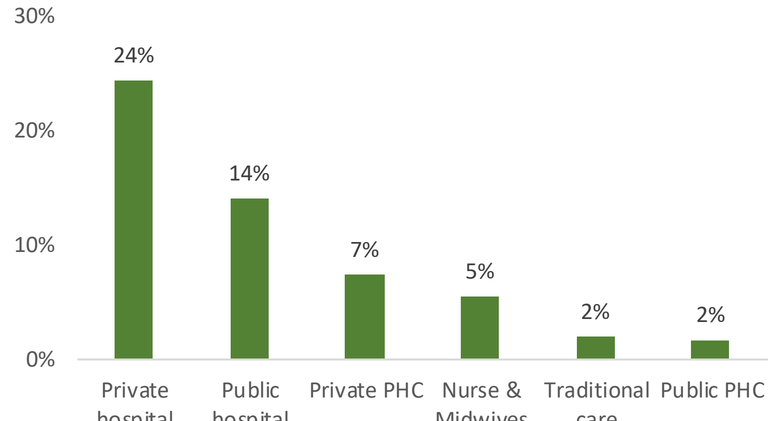
Source: BPJS-K 2021

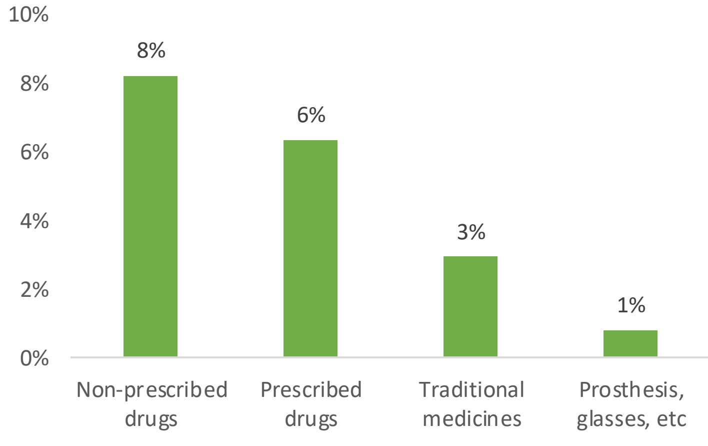


OOP Components in 2021

Source: Indonesia National Socioeconomic Survey 2021

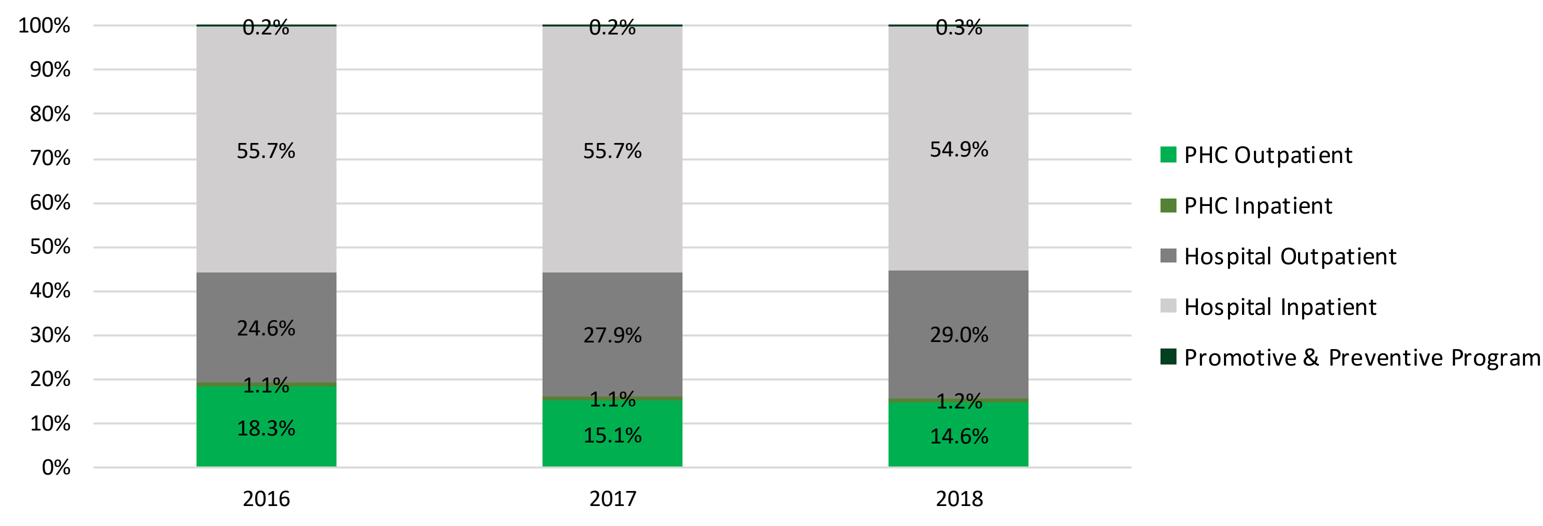






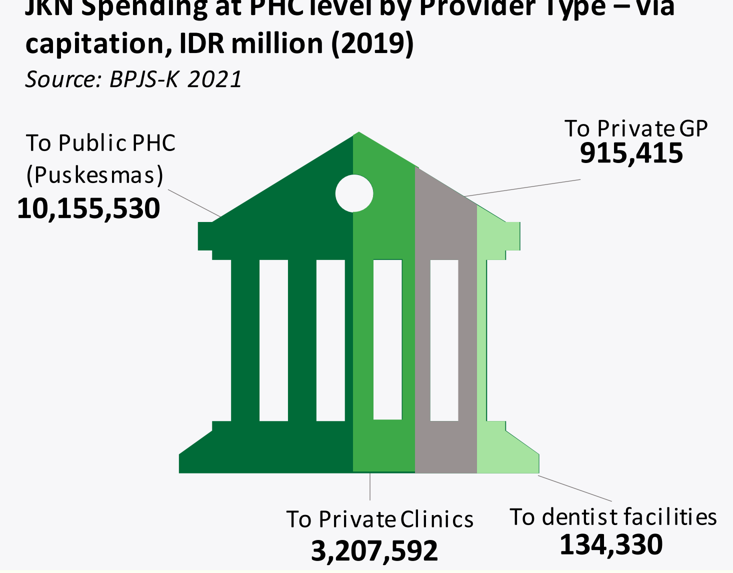
JKN spending is largely at the higher, more costly hospital levels and not at the cheaper, PHC level. The large costs of JKN are of great concern to the Government of Indonesia and they are actively exploring reforms to the scheme to ensure its sustainability.

Proportion of Costs of Health Care in JKN Program, by source (2016-2018) in IDR million



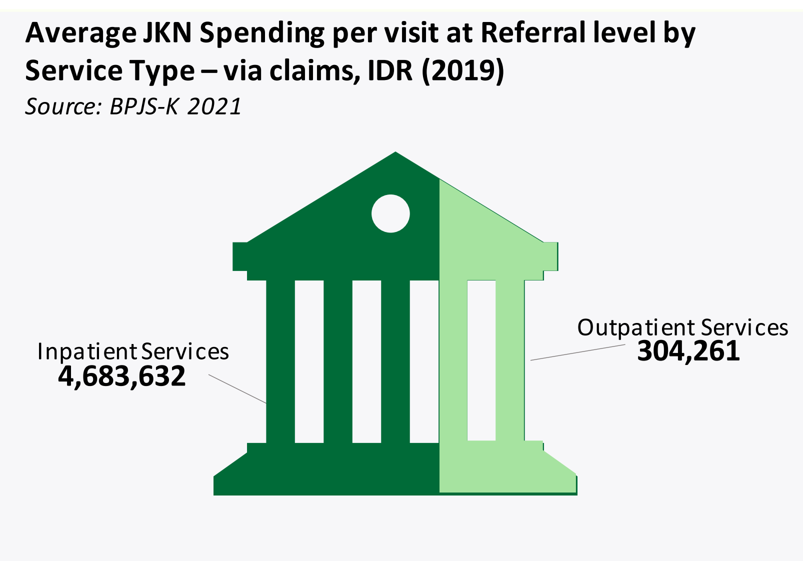
JKN Spending at PHC level by Provider Type – via capitation, IDR million (2019)

Source: BPJS-K 2021



Average JKN Spending per visit at Referral level by Service Type – via claims, IDR (2019)

Source: BPJS-K 2021



Utilization of Health Services per 100,000 members (2015-2019)

Source: BPJS-K 2021